Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
AND PEAN OF CONNECTION			A. BUILDING:			
		IL6014377	B. WING		C 04/12/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
WARREI	N BARR LINCOLNSHI	RE	STOWN LA			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE	
S9999	Final Observations		S9999			
	STATEMENT OF L	ICENSURE VIOLATIONS	на примента на			
		Seneral Requirements for				
	Nursing and Persor	nal Care				
b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.						
	Section 300.1630 Administration of Medication					
	shall be used and coprescriber's orders to administration of me Medication records accompanied by recomeans of easy, accompanied by records name, diagnoses, k medications, dosago available, a history non-prescription me resident during the State facility.	edicine to each resident. shall include or be cent photographs or other urate resident identification. shall contain the resident's nown allergies, current es, directions for use, and, if		Attachment A		
	not be administered		200	Statement of Licensure Vi	olations	

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE 04/27/16 Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

* STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER:					
		The state of the s					
		IL6014377	B. WING		E .	C 1 2/2016	
NAME OF	ספטעות מין מין מין מין				04/	12/2016	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
WARRE	N BARR LINCOLNSHI	KE	ESTOWN LA				
	0.111.45.46		SHIRE, IL	50069			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 1	S9999				
	Section 300.3240 A	huse and Neglect					
	Occitor 500.5240 A	buse and Neglect					
	 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) THESE REGULATIONS WERE NOT MET AS EVIDENCED BY: Based on interview and record review the facility 						
7.00							
	failed to ensure the	staff gave medications to the				***	
	right resident. This	failure contributed to (R1)					
	being hospitalized to rate.	or a significant drop in Heart		1			
		of eleven residents (R1) in the					
	This applies to one of eleven residents (R1) in the sample reviewed for Medication Administration. The findings include: R1 was admitted on March 17, 2016, with diagnoses of syncope, pain, dementia without behaviors, ataxic gait, falls and hypertension. R1's face sheet date March 17, 2016 does not show R1 having a medical diagnosis of diabetes mellitus or bradycardia. R1's March 27, 2016 Physician orders (POS) and Medication Administration Record (MAR), include the following medications: Clonidine 0.1mg,						
and the state of t							
						S. S	
						The state of the s	
						ROALVOIR DE LA CONTRACTOR DE LA CONTRACT	
						A SALAR PARTY OF THE SALAR PARTY	
						TOTAL CONTRACTOR OF THE PROPERTY OF THE PROPER	
		itions: Clonidine 0.1mg, le 50,000 units, Lisinopril 40				A CONTRACTOR OF THE CONTRACTOR	
		ate Extended Release				O Control of the Cont	
400	capsule 4mg, Ceftin	250 mg, Diltiazem capsule					
	Extended release 18						
		at 9:00 AM, E11 (Licensed				TAXOSIMA	
WHITE PROVIDE ACT	Practical Nurse- L.P.	N.) administered R1's			-		
	On March 27, 2016	per physician orders. at 9:15 AM, E3 (L.P.N.)				an and an	
	administered R2's r	nedications to R1. The			and the second s		
	medications were: M				Period (A)-Chalanne		
		, Asprin 81 mg, Atenolol					
;	50mg, Glyburide 5mg	g, Multivitamin, Vitamin C					
		2,000 units, and Gabapentin				Bellingson and a second	
	300mg.						
	KI'S Nurses note dat	ted March 27, 2016 shows					

Illinois Department of Public Health

Illinois Department of Public Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:				
WARREN BARR LINCOLNSHIRE SUMMARY STATEMENT OF DEFICIENCES LINCOLNSHIRE, IL 60069		IL6014377 B. WING		j				
CALL D. PROVIDER'S PLAN OF CORRECTION PREFIX TAGE SUMMARY STATEMENT OF DEFICIENCIES D. PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAGE PREFIX PAGE PREFIX PAGE PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPILETE DATE	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	 Special compression of the compression	week commanded committees are seek special as well-as an about a function of the committees and committees and	
LINCOLNSHIRE, IL 60099 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 2 E11 (L.P.N.) witnessed R1 getting additional medication. The medication given at 9:15 AM was found to be given in error. R1's pulse rate was 42 at 4:10 PM. R1 was sent to the hospital at 4:50 pm diagnosed with "medication induced bradycardia." R1 returned to the facility on April 1, 2016 with the additional admitting diagnosis of unspecified bradycardia and poisoning by unspecified drugs. On April 12, 2016 at 12:15 PM, E3 (L.P.N.) stated she walked into R1's room and R1 stated "Didn' t I already get these?" E3 (L.P.N.) stated to R1, "This is the first time I am giving you medications, the other time I just gave you water." E3 stated R1 took the medications at this time. E3 (L.P.N.) stated to the additional patients she received that morning. E3 (L.P.N.) stated she glanced at R2's picture in the Electronic Medical Record but did not make the correlation or check R1's I dentification wrist band before administration before administering medications. On April 12, 2016 at 12:30 PM, E4 (Nursing Supervisor) stated E3 (L.P.N.) was in a hurry and did not check the five rights of medication administration before administering medication administration before before administering medication administration before administering medication administratio			150 JAME	STOWN LAI	NE .			
PREFIX TAG (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 2 E11 (L.P.N.) witnessed R1 getting additional medication. The medication given at 9:15 AM was found to be given in error. R1's pulse rate was 42 at 4:10 PM. R1 was sent to the hospital at 4:50 pm diagnosed with "medication induced bradycardia." R1 returned to the facility on April 1, 2016 with the additional admitting diagnosis of unspecified drugs. On April 12, 2016 at 12:15 PM, E3 (L.P.N.) stated she walked into R1's room and R1 stated. "Didn't 1 laready get these?" E3 (L.P.N.) stated, "I completely ignored that red flag." E3 (L.P.N.) stated to R1, "This is the first time I am giving you medications, the other time I just gave you water." E3 stated R1 took the medication at this time. E3 (L.P.N.) stated to handle the additional patients she received that morning. E3 (L.P.N.) stated she glanced at R2's picture in the Electronic Medical Record but did not make the correlation or check R1's lidentification wrist band before administering medications. On April 12, 2016 at 12:30 PM, E4 (Nursing Supervisor) stated E3 (L.P.N.) was in a hurry and did not check the five rights of medication administration before administering medication.	WARREN	BARK LINCOLNSHII	RE LINCOLN	SHIRE, IL 60	0069			
PREFIX TAG TAG (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 2 E11 (L.P.N.) witnessed R1 getting additional medication. The medication given at 9:15 AM was found to be given in error. R1's pulse rate was 42 at 4:10 PM. R1 was sent to the hospital at 4:50 pm diagnosed with "medication induced bradycardia." R1 returned to the facility on April 1, 2016 with the additional admitting diagnosis of unspecified drugs. On April 12, 2016 at 12:15 PM. E3 (L.P.N.) stated she walked into R1's room and R1 stated. "Didn't 1 laready get these?" E3 (L.P.N.) stated, "1 completely ignored that red flag." E3 (L.P.N.) stated to R1, "This is the first time I am giving you medications, the other time I just gave you water." E3 stated R1 took the medications at this time. E3 (L.P.N.) stated E11 (L.P.N.) walked by and asked me whose medication I gave? E3 (L.P.N.) stated at this time she realized it was the wrong resident. E3 (L.P.N.) stated was not mentally prepared to handle the additional patients she received that morning. E3 (L.P.N.) stated she glanced at R2's picture in the Electronic Medical Record but did not make the correlation or check R1's lidentification wrist band before administering medications. On April 12, 2016 at 12:30 PM, E4 (Nursing Supervisor) stated E3 (L.P.N.) was in a hurry and did not check the five rights of medication administration before administering medication administration before administering medication administration before administering medication administration before administering medication.	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF C	ORRECTION	(Y5)	
E11 (L.P.N.) witnessed R1 getting additional medication. The medication given at 9:15 AM was found to be given in error. R1's pulse rate was 42 at 4:10 PM. R1 was sent to the hospital at 4:50 pm diagnosed with " medication induced bradycardia." R1 returned to the facility on April 1, 2016 with the additional admitting diagnosis of unspecified bradycardia and poisoning by unspecified drugs. On April 12, 2016 at 12:15 PM. E3 (L.P.N.) stated she walked into R1's room and R1 stated "Didn't I already get these?" E3 (L.P.N.) stated, "I completely ignored that red flag," E3 (L.P.N.) stated to R1, "This is the first time I am giving you medications, the other time I just gave you water." E3 stated R1 took the medications at this time. E3 (L.P.N.) stated E11 (L.P.N.) walked by and asked me whose medication I gave? E3 (L.P.N.) stated at this time she realized it was the wrong resident. E3 (L.P.N.) stated she was not mentally prepared to handle the additional patients she received that morning. E3 (L.P.N.) stated she glanced at R2's picture in the Electronic Medical Record but did not make the correlation or check R1's Identification wrist band before administering medications. E3 (L.P.N.) stated she did not follow the five rights of medication administration before administering medications. On April 12, 2016 at 12:30 PM, E4 (Nursing Supervisor) stated E3 (L.P.N.) was in a hurry and did not check the five rights of medication administration before administering medication	PREFIX			PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE IE APPROPRIATE	COMPLETE	
medication. The medication given at 9:15 AM was found to be given in error. R1's pulse rate was 42 at 4:10 PM. R1 was sent to the hospital at 4:50 pm diagnosed with "medication induced bradycardia." R1 returned to the facility on April 1, 2016 with the additional admitting diagnosis of unspecified bradycardia and poisoning by unspecified drugs. On April 12, 2016 at 12:15 PM, E3 (L.P.N.) stated she walked into R1's room and R1 stated "Didn' t I already get these?" E3 (L.P.N.) stated, "I completely ignored that red flag," E3 (L.P.N.) stated to R1, "This is the first time I am giving you medications, the other time I just gave you water." E3 stated R1 took the medications at this time. E3 (L.P.N.) stated E11 (L.P.N.) walked by and asked me whose medication I gave? E3 (L.P.N.) stated at this time she realized it was the wrong resident. E3 (L.P.N.) stated she was not mentally prepared to handle the additional patients she received that morning. E3 (L.P.N.) stated she glanced at R2's picture in the Electronic Medical Record but did not make the correlation or check R1's Identification wrist band before administering medications. E3 (L.P.N.) stated she did not follow the five rights of medication administration before administering medications. On April 12, 2016 at 12:30 PM, E4 (Nursing Supervisor) stated E3 (L.P.N.) was in a hurry and did not check the five rights of medication administration before administering medication	S9999	Continued From page	ge 2	S9999				
and that is why the medication error occurred. On April 12, 2016 at 11:55 AM, Z3 (Nurse Practitioner - N.P.) stated she was called around 9:15 AM, E3 (L.P.N.) administered additional medications to R1. Z3 (N.P.) stated she gave		E11 (L.P.N.) witness medication. The medication. The medication. The medication. The medication and point of the factorial and th	sed R1 getting additional edication given at 9:15 AM en in error. R1's pulse rate R1 was sent to the hospital at with "medication induced acility on April 1, 2016 with the diagnosis of unspecified soning by unspecified drugs. 12:15 PM, E3 (L.P.N.) stated soning by unspecified drugs. 12:15 PM, E3 (L.P.N.) stated soning by unspecified drugs. 12:15 PM, E3 (L.P.N.) stated "Didn'e?" E3 (L.P.N.) stated, "I that red flag." E3 (L.P.N.) is the first time I am giving e other time I just gave you R1 took the medications at I.) stated E11 (L.P.N.) walked nose medication I gave? E3 is time she realized it was the (L.P.N.) stated she was not on handle the additional did that morning. E3 (L.P.N.) at R2's picture in the Record but did not make the R1's Identification wrist band g medications. E3 (L.P.N.) sollow the five rights of ration before administering medication e administering medication e administering medication medication error occurred. 11:55 AM, Z3 (Nurse stated she was called around administered additional	\$9999				

Illinois Department of Public Health

Illinois Department of Public Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6014377	B. WING		04/	12/2016	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
WARREN	N BARR LINCOLNSHI	KF	STOWN LA SHIRE, IL 6				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
S9999	Continued From page concern for R1 was	the anti-arrhythmic	S9999				
	medication given. EPM, R1's heart rate (N.P.) stated R1 wa with a diagnosis of r bradycardia. On April 12, 2016 at (Administrator/Direct (L.P.N.) gave R2's 27, 2016. On April 12, 2016 at Nurse- R.N.) stated proper medications use the picture, residuate of birth to verify The undated Facility Procedure shows: It	E3 (L.P.N.) stated around 4:00 e was between 42-47. Z3 s admitted to a local hospital medically induced					
lineis December							

(X2) MULTIPLE CONSTRUCTION